The Pickering Report, Part III: what the public thinks

The third part of the Pickering Report (Parts I and II can be found in CMAJ December issues) presents recommendations that stemmed from the public hearings, public opinion survey, and the physician questionnaire. Commissioner Edward Pickering reports that papers by A. Peter Ruderman, school of hygiene, University of Toronto, and Thelma McCormack, department of sociology, York University, also contributed significantly to his suggestions. OMA published these papers appended to Pickering's study and copies are available through the OMA.

Out of all the material available to the study — the public opinion and doctors' surveys, the public hearings and personal interviews — certain identifiable patterns emerged. It is my evaluation of these patterns that has led to the following findings and recommendations.

It is not easy to match the recommendations precisely to the terms of reference. The first and third terms ask general, almost philosophical questions. The second and fourth are specific and related questions.

I have made no particular attempt to relate all the material specifically to one or other of the terms of reference. My observations and recommendations are interrelated and interwoven but I hope in total they will reveal that a searching and critical examination has been given to all the terms of reference.

Develop communications

In communities such as Kingston, Thunder Bay and St. Catharines, significant numbers of individuals attended the hearings and responded to an invitation to ask questions on the briefs presented and to engage in discussion of subjects of interest to the inquiry. This open forum discussion proved most stimulating and profitable. It was not unusual to be told that the town hall type of meeting the hearings provided was the only instance of its kind involving the medical profession in a community.

In assessing the value of the public hearings, the give and take of discussion was often as important as the submissions, particularly where the "average man" and the "average woman" had the courage to say their piece in the presence of more articulate and professional spokesmen. As a result of discussion in the hearings, some important changes in point of view have understandably already taken place.

We cannot resist concluding there is an urgent need for doctors and laymen to meet on a regular basis in informal discussion groups in communities throughout the province.

As long as the oldest of us can remember, the doctor has not only been held in high respect but has appeared to dwell apart on Olympus, making pronouncements rarely, and even more rarely descending to public discussion. The discipline of their training makes doctors reticent to enter the give and take of public debate. This, however, is changing. The point of view, dispassionately and objectively expressed by physicians during the hearings, frequently corrected public misconception and set the standard for closer community involvement.

Communication is a two-way mechanism through which doctor and community stand to benefit. Through organized and orderly dialogue, the profession will have a greater perception of public needs and attitudes and will become much more responsive in meeting them. The general public too will less and less regard the medical profession as living in an ivory tower and realize that it is concerned with providing the community with the quality of medical service needed.

There is a place in the overall medical system for a more open dialogue with the public and for an effective two-way information exchange. With its medical societies in the field and its secretariat at headquarters, the OMA is in a unique position to serve as a line of communication with the public, through doctors in local communities, to the secretariat at governing bodies of the association.

Such a program can take many forms and may vary from community to community. For it to be effective, the OMA should provide expert direction from highly qualified professionals in the communications field. A casual intermittent program left largely to local and amateur initiative might produce disappointing results and defeat its very purpose.

ACCORDINGLY, I AM RECOMMENDING THAT THE OMA ESTABLISH A POLICY THAT ITS MEMBERS PERIODICALLY ENGAGE IN OPEN FORUM MEETINGS AT THE COMMUNITY LEVEL: AND, FURTHER, THAT THE OMA PROVIDE EXPERT ADVICE AND ASSISTANCE TO LOCAL MEDICAL SOCIETIES AND ACADEMIES IN ORGANIZING AND CARRYING OUT THIS PROGRAM.

It may be appropriate to mention here the subject of the doctor's communication with the patient. From all we have heard it would appear that many doctors have something to learn on this subject. Some are said, no doubt unintentionally, to frighten their patients, particularly those with limited knowledge of English. Some overawe with a manner that seems overbearing or sometimes even arrogant, assuming an attitude described by a woman appearing at one of the public hearings as "I God; you moron". Others with the best of intentions overwhelm with technical terms beyond their patients' understanding. A widely voiced complaint is that some doctors appear to think that the patient has no right to

know the facts about his condition. Fortunately, there are many exceptions to all this — doctors of sympathetic natures who relate to their patients and adjust to their backgrounds and education. A good deal of current criticism of doctors stems from their failure to find the right means of communicating with patients.

A further aspect of communications will be covered here.

Communications from the OMA, though factual or objective sometimes appear either defensive or self-serving. It is one thing to make speeches on subjects which are important to the OMA. It is quite another for a representative of the OMA to speak on a subject which is important to the public. The latter implies a sensitivity to public need for information — also an understanding of the premise that the public responds intelligently to information which is clearly and objectively stated.

PR advisory committee

In a distinguished paper Thelma McCormack, director, graduate program in sociology, York University, reviews some of the forces at work in our society motivating persons to participate in the political, economic and social life of our times. Call it what you will — participation, involvement, revolt, self-expression of the individual — this is one of the phenomena of our era.

The College of Physicians and Surgeons of Ontario some time ago took the revolutionary step of inviting a layman to sit on the complaints committee of the college. The extensive public experience of Betty Kennedy gave the committee the advantage of an informed lay point of view. As a consequence, the college has requested the minister of health for statutory authority to appoint laymen to other committees as well.

If the OMA wishes to stay in step with the times, it must find ways to enable constructive and concerned lay opinion to make its views known. It is clear that the public does not want to interfere with the purely medical aspects of the profession. But the public does want to help the profession perform more effectively where human relations and service to the public are concerned.

But how can the Ontario Medical Association bring informed lay opinion to bear on its deliberations and programs? One possibility is to arrange for lay people to be elected to the association's various governing bodies. But the danger is that no more than lip service would be given to the principle of lay participation. How effec-

tive, for example, could one or even 20 lay people be in a council of 320 doctors? Something more formal and influential is required; a system which would be highly visible both within the OMA and to the public.

IT IS FOR THIS REASON THAT I AM RECOMMENDING THAT THE ONTARIO MEDICAL ASSOCIATION ESTABLISH A PERMANENT ADVISORY COMMITTEE HAVING THE FOLLOWING OBJECTIVES:

- TO PROVIDE CONTINUITY BETWEEN COMPLETION OF THIS STUDY AND IMPLEMENTATION OF RECOMMENDATIONS;
- TO PROVIDE THE OMA WITH LAY OPINIONS, JUDGEMENTS AND EXPERIENCE WHICH WILL ACT AS A BALANCE TO THE PURELY MEDICAL AND PROFESSIONAL ORIENTATION OF THE ASSOCIATION;
- TO ACT AS A SOUNDING-BOARD FOR THE EXECUTIVE COMMITTEE AND THE BOARD OF DIRECTORS IN ALL MATTERS WHICH MAY AFFECT RELATIONS WITH THE PUBLIC;
- TO RECOMMEND TO THE ASSOCIATION RESEARCH PROJECTS THE OBJECTIVE OF WHICH WOULD BE TO IMPROVE RELATIONS WITH AND SERVICE TO THE PUBLIC;
- TO PROVIDE THE MEMBERSHIP OF THE OMA AND PARTICULARLY THE BOARD OF DIRECTORS WITH OPINIONS ON PROPOSED POLICIES AND PROGRAMS SO THAT DECISIONS CAN BE MADE ON THE BASIS OF BOTH MEDICAL AND LAY POINTS OF VIEW;
- TO INFORM THE OMA OF SOCIAL CHANGES WHICH, FROM A LAY POINT OF VIEW, REQUIRE ITS CONSIDERATIONS.

The appointment of such a committee would be one of the most constructive steps which the Ontario Medical Association could take. It will signify, in a practical way, the association's commitment to listen to public opinion. It may be argued that such a move will be an opening of the door to halls where the layman has no business. This study has shown that there are corridors where the public and government insist they do have business. In any case, if an advisory committee represents an opening of doors, we see the doors swinging the other way: allowing the profession better to understand, respect and respond to the social environment in which it functions.

To implement this recommendation will demonstrate a change of attitude on the part of the association, which the community at large will be quick to recognize as highly progressive.

The advisory committee should have a dual capacity. In the first place, its services should be available, through the executive committee of the OMA, to any of its constituent parts, whether the council, the board, the executive committee or the local medical societies or the individual sections of the various specialties.

Second, to give the advisory committee a role which it could develop

"Physicians with good intentions may overwhelm with technical terms."

on its own initiative it should be empowered to raise with the executive committee of the OMA any matters it deems of sufficient importance for study and examination.

This duel procedure would provide the advisory committee with a mandate of initiative and enterprise relative to the ongoing relationship of the public and the profession.

To minimize expense but provide necessary clerical support, the advisory committee should have reasonable access to the services of the secretariat of the OMA.

Under this concept, the role of the committee will be advisory only, with no statutory or voting authority within the organization of the OMA itself. However, if adopted with a genuine desire to draw the lay community into a closer relationship with the professional organization representing doctors, it should become a mutually beneficial new force in the medical affairs of Ontario.

How should the committee be selected?

The qualifications of the advisory council to this study have been described earlier. The council is not entirely representative of all segments of the public. No reasonably sized, or workable, committee can be. But it is a diversified group distinguished by the quality of the counsel it has given this study.

Based on my own knowledge of the effective work of this council, I can sincerely urge the Ontario Medical Association to enlist its members as the initial personnel of the advisory committee.

The success of such an advisory and consultative resource will depend in large measure on the acceptability of the committee's membership both to itself and to the association. It should be borne in mind that the committee will have no regulatory authority and will be functioning on behalf of a voluntary association. Keeping these considerations in mind, I would recommend that vacancies or additions be filled by the advisory committee from a panel of names submitted by the executive committee of the Ontario Medical Association.

Management service

As emphasized elsewhere, there is no reason to believe the medical profession is any more likely to escape the pressures and demands of consumerism than any other profession or business which charges a fee for a service rendered or a price for a product sold.

Consumerism is not in the slightest degree interested in maintaining the status quo of the establishment. A well informed, inquisitive and concerned public is increasingly making its demands known.

Patient complaints relating to office procedure should not be surprising. Almost nothing in a doctor's training has prepared him for the requirements of running a practice.

He has been told little if anything about how to manage himself and his time; how to manage and to deal with patients; how to keep books and manage financial affairs; how to manage staff whether it consists of one person or more; how to relate to his customers, his patients; how to make the most effective use of a telephone answering service; how to program appointments so that patients will not have to sit interminably in waiting rooms; how to lay out and decorate offices.

These are a few of the many management areas for which a doctor goes into practice almost completely unprepared, though most of these have a direct bearing on the quality of service he is able to give his patients.

A number of specific criticisms were made in all parts of the province about service failures in the administration of the practitioner's office today. These complaints parallel those voiced in the public opinion survey.

Apart from the difficulty of getting a doctor and of making an appointment, the public complain of long and, to them, unnecessary or unexplained delays in seeing the doctor when an appointment has been made. The expression was used more than once that

doctors seem to make all their appointments for two o'clock in the afternoon.

There are, of course, many contingencies which may cause delays before the doctor can see his patient. Not least, is the failure of patients to show up for appointments, or to cancel at the last moment, which often leads doctors to overbook. But there was the inescapable impression that a much better job needs to be done in organizing the flow of patients through doctors' offices.

Another widely voiced complaint was that the doctor's telephone answering service is inadequate and impersonal to the degree that it erects a barrier between him and the public.

It should be acknowledged that doctors are developing rosters in many communities to cover off one another at night and on week-ends. But obtaining this information was stated to be difficult if not impossible for many patients. Since the telephone is probably the most important single instrument of communication, it should be possible for the medical profession to devise a telephone answering service for nights, holidays and week-ends, for which personnel would be trained and motivated to help people requiring assistance. A service of this kind would in itself vastly improve the attitude of the general public toward the profession.

Many local medical societies are working on this problem with varying degrees of succss. Some lists of physicians able to take new patients are available. But the methods of informing the public on how to obtain this information are seriously deficient.

The practising physician needs expert assistance relating to office methods and systems designed to lighten the doctor's load and to improve service to patients.

That some aspects of the service we are proposing have been performed by the secretariat is recognized. However, a comprehensive management service provided by trained specialists in this field, free from all other responsibilities, is acutely needed by the public and the profession.

I AM THEREFORE RECOMMENDING THAT THE OMA INAUGURATE A MANAGEMENT SERVICE AS A SEPARATE BRANCH OF ITS SECRETARIAT.

The management service could initially consist of only one person. He should be a highly qualified management generalist preferably with a background in a service industry. It is important that he be given a high level of authority and responsibility. In addition to working closely with the board and executive committee, he should have a close working relationship with the advisory committee.

Among other things, this management service should conduct research into the organization of doctors' offices from the point of view of layout, attractiveness, of appointment and billing procedures, of tax returns and of the increasing burden of completing innumerable report forms.

"Who knows better than the general surgeon if there is in fact a surplus in his specialty?"

The demand upon doctors for filling out forms and reports, often repetitive and exhaustive in character, has reached a ludicrous stage seriously impairing the doctor's productive time. These include innumerable forms required by government, by workmen's compensation boards, by the Unemployment Insurance Commission, the private insurance industry, by employers and unions in connection with the accident and illness provisions of collective bargaining agreements. The management service could seek the cooperation of various levels of government with a view to evolving simplified procedures to reduce the present morass of forms which an exhausted physician is expected to complete after a full day of practice and, of course, without compensation.

The service failures which I have been recounting are irritating to the public and yet are capable of speedy and economic solution. It is false economy to have committees of hard pressed physicians and surgeons attempting to develop system procedures that professionals in these fields could produce readily and at reasonable cost.

I recommend to the OMA that it obtain the highest calibre of specialized assistance to organize a telephone answering service for the medical profession in either Metro Toronto or in one of the other larger cities. This answering service might be given the appropriate name of Medi-Tel. Once established and working effectively in one community it can then be progressively applied with suitable local adaptations to other regions of the province.

The expertise here recommended should also provide assistance to doctors in the most effective ways of organizing rosters for night, weekend and vacation periods, with professionally developed information programs to make this service easily available to the public. This service should also include the development and continuous updating of referral lists by specialty and community area and an educational program to encourage the public to retain the services of a primary physician before crisis occurs — all too often in the middle of the night.

This concept of business management assistance can be carried a step further. A medical business manager fulfilling service requirements of these kinds, particularly in major communities of the province, is desperately needed. The management service could train medical business managers to counsel doctors on office management, establish liaison with health-oriented organizations in the community, cooperate with the news media and act as a catalyst between the profession and the community.

Organizing public forums as earlier described could also come within the responsibility of the local medical business manager. Once established, he would also serve as the point of inquiry for the public on many service matters affecting the profession.

Why should the physician who devotes so much time without compensation to hospital committees and to the clinical and scientific aspects of his profession, expend himself, on a haphazard and amateur basis, on business and administrative procedures which others are better qualified to carry out?

I am convinced that, through the application of sound business procedures, the profession will become more efficient, more responsive to community interests and enjoy more satisfaction from a more efficiently run practice.

This proposal in no way implies that good business practice does not apply within the secretariat of the OMA itself. It concerns itself with the need of improving business methods in the practice of medicine in the many communities throughout the province.

Neither does the proposal ignore excellent work on the part of present members of the secretariat in seeking to provide some assistance along the lines suggested.

Our concern is that the service failures which we have described are so widespread and so serious as to impair

quality of service to the public, reduce the individual doctor's productivity and generate criticism, which if continued may well result in some form of remedial action by government.

To provide assistance to the profession on an adequate scale and within the time limits available, specialized management skills should be set up in a separate branch of the secretariat free of all other responsibilities.

It would be manifestly unfair to expect present members of the secretariat with other types of training and qualification — already fully engaged — to undertake this assignment as a sideline, especially when it will require considerable absence working with the profession in their local communities.

One of the most common questions throughout the public hearings was whether there were sufficient medical practitioners. There was almost universal criticism by doctors individually, by medical groups and by laymen, of the alleged shortage of primary physicians — the general physician and the family practitioner. Here again there was a clear parallel to the findings of the public opinion survey.

The general public complained about the difficulty of finding a doctor upon moving into a new community.

Families with established physicians complained of having to wait for weeks to receive an appointment.

Almost two-thirds of the people participating in the survey felt there were not enough general practitioners. 56% were not confident of getting a doctor in an emergency.

There was lament about over crowded waiting rooms, with "assembly line production methods", and waiting periods of up to two and three hours.

A common criticism was that under the pressure of heavy workloads too many doctors are treating patients impersonally, in contrast to the pre-medicare era when the family physician had a personal relationship with them.

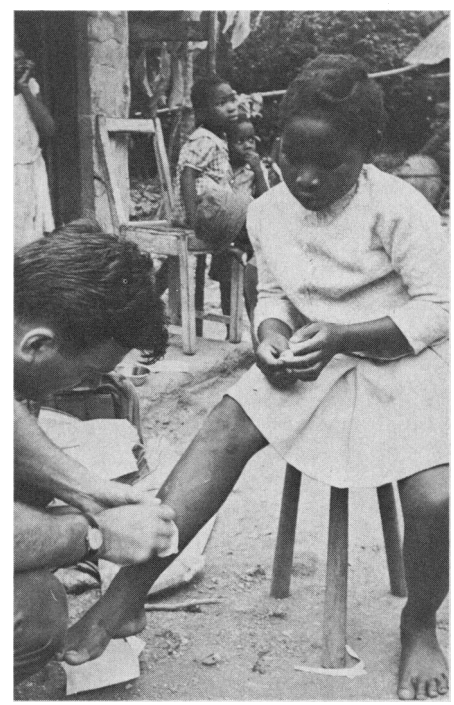
Physicians themselves reported having to work 60 and even over 70 hours a week. One doctor said there was a deficiency of physicians, but "I have never seen a deficiency of patients". In many communities, the profession is on record as having urged an increase in its numbers. Over half the doctors replying to the physicians survey felt the medical schools are admitting too few students.

Yet we face the paradox of distinguished figures in the health field quoting statistics showing that Ontario has one of the best physician population ratios in the world and asserting that the problem is simply one of uneven distribution of doctors by specialty or geographic areas. Even if this were true as a statistical proposition, it is of little comfort to a desperate mother trying to find a physician for a seriously ill child.

It was placed on the public record in Sudbury that, until recently, there was one area within the city and its nearby outskirts to the north in which 45,000 people lived who had to travel up to 15 miles to get to a doctor's office. The Toronto hearing was also told that Ward Seven, a low-income inner-core community in downtown Toronto, has only one primary physician for 1400 population as against the statistical average for metropolitan Toronto of one to 494.

We have had neither the time nor the resources to indulge in the statistical numbers game in the field of medical manpower. But if there is a shortage of doctors, real or apprehended, the public blames not the medical schools and the provincial government which control the class size of the medical schools. It is the doctors themselves who are blamed, and blamed on the gross misconception that they are limiting their numbers to maintain a high earning potential.

There were also many protests that the majority of doctors currently being registered have been trained outside Ontario. Doctors and laymen alike took the position that it is wrong for Ontario to be allowing less wealthy countries to train doctors for our use and to be taking so many doctors away from other jurisdictions where they are needed even more badly. Regret was frequently expressed that opportunity is not being given to more



National Defence photo

A moral question: Ontario's isn't the greater need.

Ontario youth for a professional career in medicine.

All this should suggest to the medical profession that it is in its own interests as well as that of the general public, to take the initiative in researching the true needs of medical manpower in Ontario. Who knows better than the general surgeon if there is in fact a surplus in his specialty?

Some of the organizations in the medical fields have in recent years been studying some aspects of medical manpower — for example the College of Physicians and Surgeons and the Council of Health among others. In a paper recently published by the McMaster medical school, Drs. Spaulding and Spitzer examine the subject and make a plea for the coordination of data produced by all the organizations working on this problem. They conclude with a recommendation for the establishment of a medical manpower data unit.

> We are convinced that the province of Ontario (and all the other provinces) should establish a medical manpower data unit. It could be sponsored jointly by the Ontario Medical Association, the College of Physicians and Surgeons of Ontario, the Department of Health and the medical schools of the province. This unit should have free access to manpower records of all these bodies and should produce, at least every two years, accurate data on the types, ages and locations of doctors in relation to population groups throughout the province. A properly constituted unit could do much better, providing not only more accurate information but also responding to specific questions on request. Ready identification of trends is needed to determine how many medical students should be graduated annually, how many and what sorts of internships and residency vacancies should be available, and what incentives or restraints are required to provide reasonably adequate numbers and types of physicians throughout the province.

The appropriate number of physicians by specialty in this province is obviously a matter of first importance. It should not be left to an ad hoc committee or to an occasional task force. The lead time for the training of doctors and surgeons is so long and the costs so immense that all the principal bodies able to contribute meaningful data should work together on a continuing basis.

But this is much more than a matter of feeding inanimate statistics into a computer. The human and the obvious factors must also be taken into account. What does it matter if Kingston has the highest number of physicians per population in the province if many of them are not in practice but are teaching at the medical school, and if the others are also servicing the Royal Military College, the penitentiaries and a large rural area with few doctors resident in it? What does it matter if a small Ontario town has an apparently adequate number of physicians when all but one of them are past retirement age? How meaningful are the figures for doctors in downtown Toronto when a high proportion of them practise almost exclusively in hospitals which draw patients not only from all parts of Ontario but from parts of the United States as well? What comfort is there in statistics showing how fortunate we are in Ontario to have such a favourable physician/population ratio, when almost 25% of the doctors on the register are not in active practice, but are in research, government and administrative work?

There are the human equations and other relevant considerations:

- What is the work load of the doctors in the community?
- Are they working excessive hours?
- Are some not working to capacity?
- To what extent does effective use of paramedical personnel increase the doctor's own productivity?
- What is the socioeconomic status of the area — a poor community may need more service?
- How far and by what means do people have to travel to obtain service?
- What is the influx of temporary summer population?

We need the realities behind the figures if they are to be meaningful and serve the public good.

The Ontario Medical Association does not have and should not have statutory responsibility or authority for determining the number of doctors needed in the province. Yet its responsibility to the public clearly suggests that it should associate itself with other bodies in examining the concept advanced by Drs. Spaulding and Spitzer. I do not think it is by accident that the authors of this paper name the Ontario Medical Association first in the group of organizations they urge to sponsor the project.

Extensive examination of the concept proposed will no doubt lead to some modifications, but the association has nothing to lose and a great deal to gain — both for the general public and its own members — in accepting a leadership role in an early and serious examination and creation of such a coordinating agency.

ACCORDINGLY, I RECOMMEND THAT THE OMA TAKE THE INITIATIVE WITH OTHER INTERESTED BODIES IN ESTABLISHING A PERMANENT MEDICAL MANPOWER DATA UNIT. ■